Mansfield Middle School Overnight Field Trip Form Grade_____

Parents'/Health Care Provider's Authorization for the Administration of Medication

Connecticut State Law and Regulations 10-212(a) requires a written medication order of an authorized prescriber (physician, dentist, advanced practice registered nurse, optometrist, or physician's assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization for the nurse (or, in the absence of the nurse, other qualified personnel in accordance with state law and regulations) to administer medication in school.

Coaches and licensed athletic trainers during intramural and interscholastic athletic events may administer medications, including inhalant and/or cartridge injector (i.e., Epi-pen) medications, for students. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. A parent or responsible adult must bring the medication to the school nurse or principal. **Medications to be administered by a coach or athletic trainer must be delivered by a parent or guardian directly to the coach or athletic trainer.** Please refer to the Board of Education Policy concerning the Administration of Medication in Schools for specific information regarding the administration of medication.

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be reviewed and/or approved by the school nurse in accordance with Board policy. For example, asthma inhalers and Epi-pens for sting or nut allergies may be self-carried. Controlled drugs may not be self-administered, except in extraordinary situations with the pre-approval of the medical advisor and nurse supervisor.

Name of student: _____Date of Birth:_____

#1.Condition for which drug is being administered: _____

Drug name:_____ Generic Name _____

Dose: _____ Route:_____ Time(s) of administration:_____

If PRN, frequency:_____ Relevant side effects:_____

If there are side effects, plan for management:_____

Medication shall be administered from (m/d/yr):_____to (m/d/yr) _____

Is this a controlled drug? Yes ___No ___. If Yes, please include DEA number: _____

The medication listed above may be <u>self-administered</u> by the student □

The medication listed above may NOT be <u>self-administered</u> by the student □

Health Provider's Name/Title_____ Prescriber's Stamp

Telephone: _____Fax:_____

Address: _____

Prescriber's Signature: _____Date:_____

Nurse authorization for <u>self-administration</u> □

Name of student: _____Date of Birth:_____

#2.Condition for which drug is being administered:_____

Drug name:_____ Generic Name _____

Dose: _____ Route:_____ Time(s) of administration:_____

If PRN, frequency:_____ Relevant side effects:_____

If there are side effects, plan for management: _____

Medication shall be administered from (m/d/yr):_____to (m/d/yr) _____

Is this a controlled drug? Yes___No___. If Yes, please include DEA number: _____

The medication listed above may be <u>self-administered</u> by the student □

The medication listed above may NOT be <u>self-administered</u> by the student □

Health Provider's Name/Title_____ Prescriber's Stamp

Telephone: _____Fax:_____

Address: _____

Prescriber's Signature: _____Date:_____

Nurse authorization for <u>self-administration</u> □

Parent/Guardian Authorization

I hereby request that the medications listed on the reverse side and/or above be administered to my child. Medications that are not approved for self-administration will be administered by qualified school personnel in accordance with Board policy. I understand that: I must supply the school with no more than a three-month supply of medication; and this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. By signing below, I give my permission for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of such medication.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____**Date:_____**

Home phone number: _____Cell :_____Work :_____